MENTAL HEALTH AND MENTAL DISORDERS

MENTAL HEALTH AND MENTAL DISORDERS

◆ *Suicide* ◆ *Depression*

Background

Mental health is the ability of an individual to negotiate the daily challenges and social interactions of life without experiencing cognitive, emotional, or behavioral dysfunction.[1]

Anxiety disorders are the most common of all the mental disorders. An anxiety disorder may make an individual feel anxious most of the time without any apparent reason. The anxious feelings may prevent a person from doing everyday activities in order to avoid the anxious feelings. Some bouts may be so intense that they anxiety may terrify and immobilize a person.[2]

Panic disorder is a type of anxiety disorder. People with panic disorder have feelings of terror that strike suddenly and repeatedly with no warning. Since they can't predict when an attack will occur, they become very anxious between episodes as they worry about when the next one will occur.[2]

Obsessive-compulsive disorder is characterized by anxious thoughts or rituals an individual feels he or she cannot control. People with OCD have persistent unwelcome thoughts or images, or by the urgent need to engage in certain rituals to temporarily ease the discomfort caused by the obsession.[2]

Schizophrenia is a chronic, severe, and disabling brain disease that causes people to suffer terrifying symptoms such as hearing internal voices not heard by others, or believing that other people are reading their minds, controlling their thoughts, or plotting to harm them.[2]

Depressive disorders are illnesses that affect mood, body, behavior, and mind to the extent that when untreated it prevents a person from functioning for weeks or months in their family or work place. They are not the normal ups and downs that everyone experiences.[2]

Only four in ten individuals with a history of at least one **mental disorder** ever obtain professional help for their illnesses and only one in four receives treatment in the mental health sector.[3]

Size

Approximately 40 million Americans, aged 15-54, experienced some sort of **mental disorder** within the past year.[3]

Nearly a third of all Americans between 15 and 54 years of age experience one or more **addictive or mental health disorders** in any year. Almost half will experience one or more episodes during their lifetime.[4]

In 1996, there were 31.8 million office visits to physicians for **mental disorders** – 1.9 million visits for **schizophrenic** disorders and 4.3 million visits for **anxiety**.[5]

Panic disorder strikes between 3 and 6 million Americans.[2]

Obsessive-compulsive disorder (OCD) afflicts roughly 1 in 50 people. OCD affects more than 2 percent of the population, meaning that OCD is more common than such severe mental illnesses as schizophrenia, bipolar disorder, or panic disorder.[2]

Approximately 1 percent of the population develops **schizophrenia** during their lifetime – more than 2 million Americans suffer from the illness in a given year.[2]

56% of females and 40% of males nationwide have reported a psychiatric disorder sometime in their lifetime.[6] **(Table 1)** 21% of females and 13% of males have reported depression.[6] 30% of females and

19% of males have reported an anxiety disorder during their lifetime.[6]

Table 1
Percent Prevalence of Psychiatric Disorders* for Those Surveyed Over a Lifetime or Within the Last 12 Months United States[6]

	Male		Female		Total	
	Lifetime	Past 12 Months	Lifetime	Past 12 Months	Lifetime	Past 12 Months
Any psychiatric disorder	40.3	20.8	56.4	37.7	48.4	29.0
Major depressive episode	12.7	7.7	21.3	12.9	17.1	10.3
Any anxiety disorder	19.2	11.8	30.5	22.6	24.9	17.2

*As defined by the Diagnostic and Statistical Manual-III-R

Seriousness

The social and economic costs of **obsessive-compulsive disorder** were estimated to be $8.4 billion in 1990.[2]

See Health Issue Briefs on Suicide and Depression

Community Concerns

Focus Group Discussion Points:

- Mental health was a priority for a majority of the community input groups, as was the concern that there are not adequate services to meet the demand for care.
- Mental health services were a major concern for the **senior** population. They did not feel that seniors have adequate access to mental health services. Medicare does not cover such services and many HMO's require additional co-pays, which make them financially inaccessible. Seniors also complained about the poor quality of the mental health services available. Many believed that providers are too quick to diagnose seniors with Alzheimer's and don't consider alternative explanations for mental deterioration – such as over-medication, under-medication (many seniors try to save money by cutting their pills in half), contraindications in medication, depression, as well as alcoholism.
- Several groups indicated that there is a shortage of mental health services for **adolescents**. There is a belief that crisis centers need to be available in the local neighborhoods.
- The **African American** group including **East Africans** recommended mental health services for problems due to immigration and assimilation. Native born Blacks wanted services related to violence in the community and family.

Risk Factors

Mental health problems can be caused by biology, environment, or a mix of both. Examples of biological causes are genetics, chemical imbalances in the body, and damage to the central nervous system, such as a head injury.

There are many environmental factors that can put young people at risk of developing mental health problems. Examples of these factors include:[7]

- Exposure to environmental toxins, such as high levels of lead;
- Exposure to violence, such as witnessing or being the victim of physical or sexual abuse, drive-by shootings, muggings, or other disasters;
- Stress related to chronic poverty, discrimination, or other serious hardships; and
- Loss of important people in the lives of young people through death, divorce, or broken relationships.

Prevention

Since the majority (74%) of people seeking care for mental health disorders go to the primary care sector, more primary health care providers need to provide effective screening, diagnosis, and referral for mental health disorders. Specific recommendations are to:[3]

- Increase the number of primary care providers who are trained to screen for mental health problems from childhood to adolescence.
- Increase the number of primary care providers who are trained to offer information and referral for parent training that focuses on the mental health needs of children, and adolescents.
- Increase the number of primary care providers who routinely review with adult and child patients their cognitive, emotional, and behavioral (including parent-child) functioning, including appropriate counseling, referral, follow-up, and the resources available to deal with any problems that are identified.

Resources

Local

Mental Health Services, Health and Human Services Agency, County of San Diego, (619) 692-8750

Mental Health Association, (619) 543-0412

Alliance for the Mentally Ill, (619) 543-1434

Crisis Team Hotline, (619) 557-0500

Heartbeat, (619) 231-0781

Children's Hospital and Health Center, Outpatient Psychiatry, (619) 576-5832

Mesa Vista Hospital, (619) 278-4110

National

National Institute of Mental Health, National Institutes of Health, *www.nimh.nih.gov*

Violence Policy Center, *www.vpc.org*

National Mental Health Services, *www.mentalhealth.org*

Centers for Disease Control and Prevention, *www.cdc.gov*

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SUICIDE

Background

Over 60% of all people who commit suicide suffer from major depression.[1]

Persons contemplating suicide exhibit behavior such as:[1]

- Drug and alcohol use
- Unusual neglect of personal appearance
- Personality change
- Persistent boredom
- Difficulty in concentrating

Firearms are used in 60% of suicides.[2]

Size

San Diego County[3]

In San Diego County, 337 people committed suicide in 1996[3] and 354 in 1997.[4]

San Diego County suicides

- **1996 Rate:** 11.6 per 100,000 population per year, age adjusted; 12.6 not age adjusted. **(Table 1)**
- **1993 – 96 Trend:** Decreased 14.2 – 12.6 per 100,000 (not age adjusted) **(Figure 1)**

A 1997 survey of San Diego City Schools high school students found that 23% had seriously considered attempting suicide and 10% had actually attempted suicide during the 12 months preceding the survey.[5]

National

Over 32,000 people commit suicide each year in the United States.[1]

In 1996, there were 30,862 deaths from suicide – an age adjusted death rate of 11 deaths per 100,000 population.[6]

In 1992, persons over the age of 65 accounted for almost 20% of all suicides even though they comprise 13% of the population.[7]

Senior men account for 81% of all suicides committed by the elderly.[1]

Seriousness

Average Years of Productive Life Lost in San Diego: 26.2 years per death

Healthy People 2000 Objective: The 1996 San Diego County rate of suicide (11.6) is higher than the Healthy People 2000 Objective (10.5).

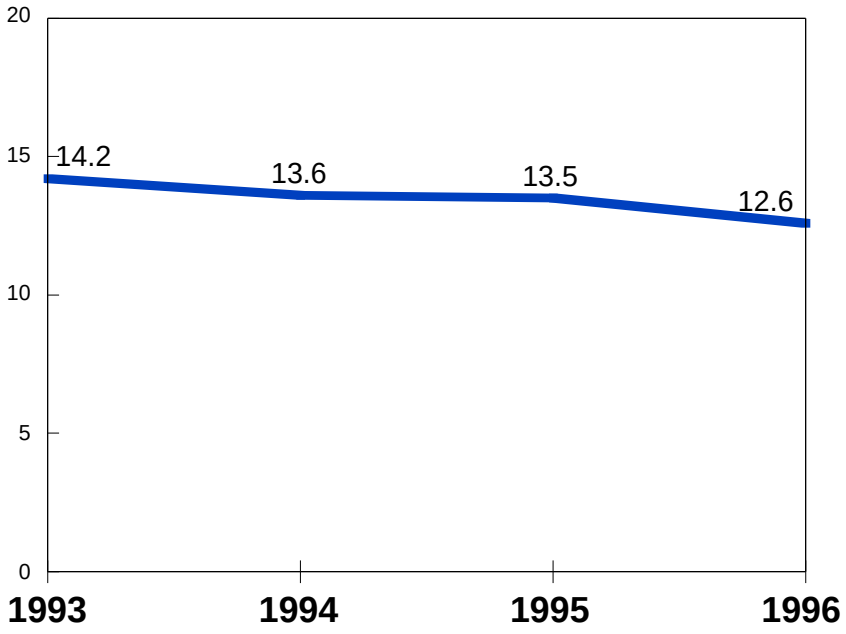
Suicide is the ninth leading cause of death in the United States.[8]

Nationally, for 15 to 24 year olds, suicide is the third most common way to die, after unintentional injuries and homicide.[4] It results in the highest number of years of productive life lost for this age group.[9]

Table 1
San Diego vs. the Nation—Suicide Rates*,[3]

San Diego County 1996**	County Trends 1993-1997	California 1995	National 1993**	HP2000 Objective**
11.6 (age adjusted)	Decreased 14.2-12.6 (not age adjusted)	11.7 (not age adjusted)	11.2 (age adjusted)	10.5 (age adjusted)

Figure 1
Suicide Rate* Trends, San Diego County 1993-1996[3]



* Rates per 100,000 population.

**Age adjusted using the US 1940 standard million population

Suicide is the second leading cause of death among college students and the fourth leading cause of death among 10-14 year olds nationwide.[1]

An estimated 210,000 persons attempt suicide each year, resulting in over 10,000 permanent disabilities, 155,500 physician visits, 259,200 hospital days, over 630,000 lost work days, and over $115 million in direct medical expenses.[9]

Risk Factors

Risk factors for suicide include:[1]

- Past history of attempted suicide and suicidal ideation, talk, or preparation
- Psychiatric problems such as depression, hopelessness, schizophrenia, substance abuse, and personality disorders
- Situational risk factors such as stressful life events or inadequate social support networks
- Exposure to suicide or suicidal behavior
- Genetic disposition or family history of suicidal behavior
- Accessibility of firearms

The most important risk factor for suicide is psychiatric illness. The majority of suicide victims have affective, substance abuse, personality or other mental disorders. Persons with a history of one or more psychiatric hospital admissions carry a particularly high risk of suicide.[9]

Other risk factors for suicide and attempted suicide, particularly in persons with underlying mental or substance abuse disorders, include social adjustment problems, serious medical illness, living alone, recent bereavement, personal or family history of suicide attempt, family history of completed suicide, divorce, separation, and unemployment.[9]

Risk of suicide is almost five times higher for persons who live in a household where at least one firearm is kept, when compared with persons who live in a household free of guns. [9]

High Risk Populations

Ages: In 1996, individuals ages 65 and older had the highest suicide rate in San Diego County (24.1 per 100,000 population) (**Fig. 2**).

Gender Most Affected:

- In San Diego County, the suicide rate for males (19.5, not age adjusted) is more than three times higher than for females (5.4, not age adjusted). **(Fig. 3)**
- Females are more likely to think seriously about suicide, to make a suicide plan, and attempt suicide.[7]
- Almost 13.9% of San Diego City Schools high school girls surveyed in 1997 said they attempted to commit suicide in the past year compared to 4.9% of boys.[5] **(Fig. 4)**

Race/Ethnicity:

- Whites have the highest suicide rate (13.9 age adjusted) compared to other ethnicities/races and the population overall (11.6 age adjusted). **(Fig. 5)**

Figure 2
Suicide Rates* by Age Group
San Diego County 1996[3]

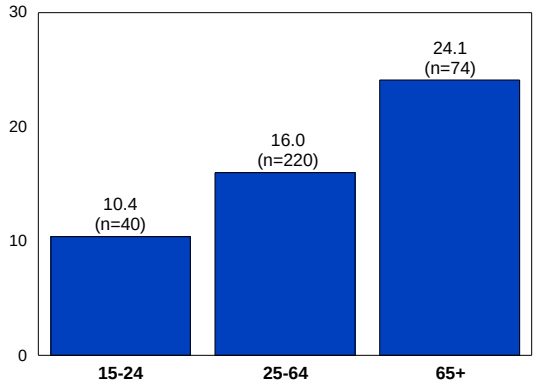


Figure 3
Suicide Rates* by Gender
San Diego County 1996[3]

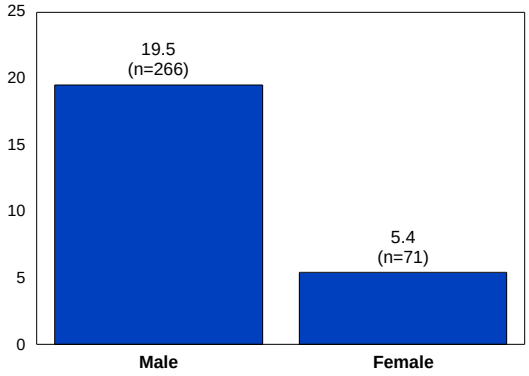


Figure 4
Percentage of Surveyed High School Students Reporting Attempted Suicide by Gender
1997[5]

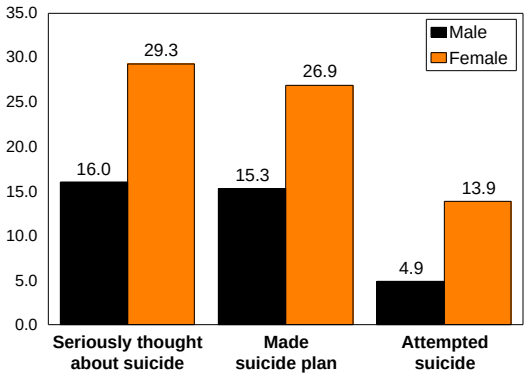
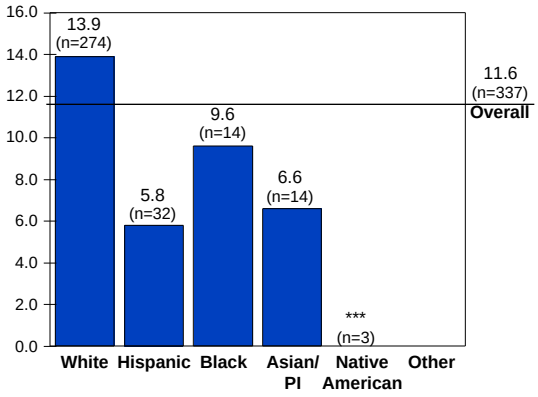


Figure 5
Suicide Rates* by Ethnicity/Race
San Diego County**
1996[3]



* Rates per 100,000 population

**Age adjusted using the US 1940 standard million population

***Rate not calculated for less than 5 cases

Special Populations:

- People with AIDS have a suicide risk up to 20 times higher than the general population.[1]
- Gay and lesbian adolescents have some of the highest rates of suicides.[6]
- Widowed or divorced men also have high suicide rates.[6]

County Areas: (1996 age adjusted) **(Table 2)**

- **Regions:** Central, East
- **SRAs:** Central, San Marcos, El Cajon

Table 2
San Diego County Regions and SRAs with the Highest Suicide Rates* 1996,[3]**

San Diego	REGIONS		SRAs		
	Central Region	East Region	Central	San Marcos	El Cajon
11.6 (n=337)	16.7 (n=77)	13.1 (n=62)	24.0 (n=39)	16.5 (n=51)	14.8 (n=19)

* Rates per 100,000 population

**Age adjusted using the US 1940 standard million population

Prevention

General

Studies indicate that the most promising way to prevent suicide and suicidal behavior is early recognition and treatment of mental and substance abuse disorders.[7]

Successful suicide prevention programs should also focus on coping with stress and controlling aggressive behaviors.[7]

Limiting access to potential instruments of suicide, such as firearms and drugs, could help to prevent suicide.[9]

About one-half to two-thirds of persons who commit suicide visit physicians less than 1 month before the incident, and 10-40% visit in the preceding week.[9]

Seniors

Recognition and treatment of depression in the medical setting is a promising way to prevent elderly suicide. Most elderly suicide victims have visited their primary care physician in the month prior to their suicide.[7]

Youth

School and community prevention programs designed to address suicide and suicidal behavior as part of a broader focus on mental health, coping skills in response to stress, substance abuse, and aggressive behaviors are most likely to be successful.[7]

Youth suicide prevention needs to include social policies that limit access to firearms, alcohol, and illicit substances, as well as responsible portrayal and coverage of suicide in the media.[1]

According to the Centers for Disease Control and Prevention (CDC), screening questionnaires with direct questions such as "Have you thought about hurting yourself?" should be given to every adolescent as least once a year. Other prevention strategies include:[4]

- Educating counselors, teachers, parents, and doctors to talk more openly to students about whether they have had suicidal thoughts, and to recognize signs of hidden despair.
- Distributing pocket-sized cards with local crisis numbers and the message "This card is a cry for help". Encourage youth and others to carry the card and give it to a teacher or friend when they are having trouble expressing their suicidal feelings.

The American Academy of Pediatrics recommends asking all adolescents about suicidal thoughts during the routine medical history. The American Medical Association recommends that providers screen adolescents annually to identify those at risk for suicide.[9]

Examples of suicide prevention strategies include:[10]

- Training for school counselors, teachers, and other leaders
- Community training for health and social service providers as well as other leaders
- General suicide education
- Screening programs
- Peer support programs
- Crisis centers and hotlines
- Restriction of access to lethal instruments
- Intervention after an unsuccessful suicide attempt

Resources

Light for Life Foundation, local chapter of the Suicide Prevention Advocacy Network (SPAN), (760) 753-2535, *www.spanusa.org*

Survivors of Suicide (619) 482-0297.

American Foundation for Suicide Prevention, *www.afsp.org*

National Center for Injury Prevention and Control, *www.cdc.gov/ncipc/ncipchm.htm*

National Institute of Mental Health, *www.nimh.nih.gov/*

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DEPRESSION

Definitions

Depressive disorders are illnesses that affect mood, body, behavior, and mind to the extent that when untreated it prevents a person from functioning for weeks or months in their family or work place. They are not the normal ups and downs that everyone experiences.[1]

Two serious types of **clinical depression** are major depression and bipolar disorder.

- **Major depression**: Major depression makes it almost impossible to carry on usual activities, sleep, eat, or enjoy life. Pleasure seems a thing of the past. This type of depression can occur once in a lifetime or, for many people, it can recur several times. People with a major depression need professional treatment. [1]
- **Bipolar disorder** (manic-depressive illness): Another type of depression, bipolar disorder--or manic-depressive illness--leads to severe mood swings, from extreme "lows" to excessive "highs." These states of extreme elation and unbounded energy are called mania. This disorder usually starts when people are in their early twenties. Though unusual for this type of depression to start for the first time in later life, it requires medical treatment, whatever the person's age. [1]

Size

San Diego County

In 1996 almost 15% of San Diegans surveyed said they had ever been told by a doctor that they had depression.[2] **(Figure 1)**

National

More than 15 million people suffer from depression in the US. 1 out of 6 people experience a major depressive episode sometime during their lifetimes.[1]

Major depressive disorder is present in 5-13% of patients seen by primary care physicians.[3]

The prevalence of this disease in the general population is about 3-5%.[3]

Seriousness

In 1990 the cost of depression in the US (including direct care costs, mortality costs, and morbidity costs) has been estimated to be between $30 and $44 billion.[1]

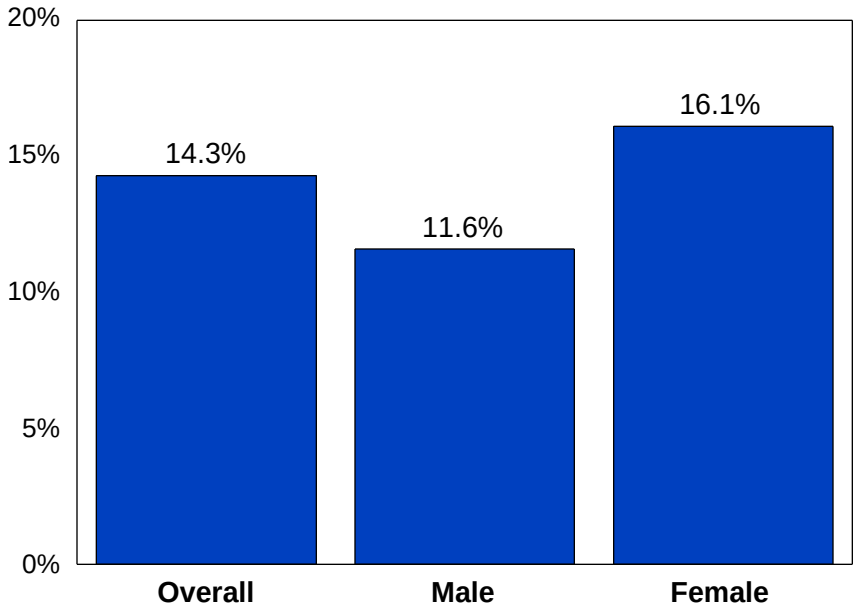
Depression is associated with approximately 50% of suicides.[3]

The number of young people suffering from depression is on the rise.[1]

Depression is a leading cause of alcoholism, drug abuse, and other addictions.[1]

At least 80% of depression cases can be treated through counseling and/or medication.[1]

Figure 1
Percentage of San Diego Adults Surveyed Who Were Told by a Doctor They Had Depression 1996[2]



Community Concerns

Focus Group Discussion Points:

- Mental health was a priority for a majority of the community input groups, as was the concern that there are not adequate services to meet the demand for care.
- Mental health services were a major concern for the **senior** population. They did not feel that seniors have adequate access to mental health services. Medicare does not cover such services and many HMO's require additional co-pays, which make them financially inaccessible. Seniors also complained about the poor quality of the mental health services available. Many believed that providers are too quick to diagnose seniors with Alzheimer's and don't consider alternative explanations for mental deterioration – such as over-medication, under-medication (many seniors try to save money by cutting their pills in half), contraindications in medication, depression, as well as alcoholism.
- Several groups indicated that there is a shortage of mental health services for **adolescents**. There is a belief that crisis centers need to be available in the local neighborhoods.
- The **African American** group including **East Africans** recommended mental health services for problems due to immigration and assimilation.

Risk Factors

Depression is usually attributed to a combination of genetic, psychological, and environmental factors including:[1]

- Genetics and inherited biological vulnerability
- Psychological make-up including low self-esteem, pessimism, and inability to cope with stress
- Change in life patterns including a serious loss, chronic illness, difficult relationship, or financial problem

High Risk Populations

Depression is more common in persons who are young, female, single, divorced, separated, seriously ill, or who have a prior history or family history of depression.[3]

Gender:

- Women are more than twice as likely to experience major depression as men.[4]
- Women of color, women on welfare, and women who are poor, less educated, or unemployed are more likely to experience depression than women in the general population.[4]

Age(s):

- Approximately 4 out of 100 teenagers get seriously depressed each year.[1]
- Among people 65 and over, as many as 3 out of 100 suffer from clinical depression.[1]

Race/Ethnicity: There are no differences in rates of depression among ethnic/racial groups. [1]

Special Populations: Depression occurs at higher than average rates in heart attack and cancer patients, persons with diabetes, and post-stroke patients. Untreated depression can interfere with the patient's ability to follow the necessary treatment regimen or to participate in a rehabilitation program. It may also increase impairment from the medical disorder and impede its improvement. [1]

Recognition

Even though effective treatments are available, only one in three depressed people gets help.[1]

Recognition and treatment of depression with psychotherapy and/or anti-depressant medication is effective in improving patient outcomes in at least 80% of the cases.[1]

Depression often co-occurs with medical, psychiatric, and substance abuse disorders. When this happens, the presence of both illnesses is frequently unrecognized and may lead to serious and unnecessary consequences for patients and families. [1]

Primary care providers do not recognize major depression in approximately half of their adult patients with this disorder. Studies show that the use of depression screening tests in primary care settings can increase clinician detection of depression through several brief (2-5 minute) questionnaires such as:[3]

- Beck Depression Inventory (BDI)
- Center for Epidemiologic Studies Depression scale (CES-D)
- Zung Self-Rating Depression Scale (SDS)

Depression screening questionnaires developed specifically for children and adolescents include the Center for Epidemiologic Studies Depression Scale for Children (CES-DC) and the Children's Depression Inventory (CDI).[3]

Sample Program

Depression: Awareness, Recognition, and Treatment (D/ART)

This is a federal government program to educate the public, primary care providers, and mental health specialists about depressive illnesses--their symptoms, diagnosis, and treatment. Sponsored by the National Institute of Mental Health (NIMH), D/ART is a collaboration between the government and community organizations to benefit the mental health of the American public. For further information write to: D/ART, National Institute of Mental Health, 5600 Fishers Lane Rockville MD 20857 or visit their website at http://www.nimh.nih.gov/newdart.

Resources

Local

Mental Health Services, Health and Human Services Agency, County of San Diego, (619) 692-8750

Mental Health Association, (619) 543-0412

Alliance for the Mentally Ill, (619) 543-1434

Crisis Team Hotline, (619) 557-0500

Heartbeat, (619) 231-0781

Children's Hospital and Health Center, Outpatient Psychiatry, (619) 576-5832

Mesa Vista Hospital, (619) 278-4110

National

National Institutes of Mental Health, *www.nimh.gov*

National Alliances for the Mentally Ill: 1-800-950-6264

National Depressive and Manic Depression Association: 1-800-826-3632

National Mental Health Association: 1-800-433-5959

References

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